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Borderline Personality Disorder Stigmatization: Bias, Discrimination, and Prejudice in the Healthcare Field

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BPD Stigmatization: Bias, Discrimination, and Prejudice in the Healthcare Field

Borderline Personality Disorder (BPD) is a personality disorder characterized by patterns of unstable moods, behaviors, and relationships. While the cause of it is unknown, the diagnosis process is based on symptoms such as unstable self-image, impulsive and dangerous behaviors, such as overspending, unsafe sex, substance abuse, and binge eating, recurring thoughts of suicidal behaviors or threats, highly changeable moods or feelings of emptiness (American Psychiatric Association, 2013). Often misdiagnosed as Bipolar Disorder, BPD is difficult to diagnose due to its symptoms overlapping with many other conditions. With all of this in mind, there has been a reluctance to work with individuals who have BPD due to the surrounding stigma. Many healthcare providers fall victim to the ideas spread that those with BPD are manipulative, aggressive, violent, and unable to be helped (Knaak et al., 2015). This stigmatization has a profound impact on how BPD clients are seen in the healthcare field and furthermore how they receive treatment. Considering this, it is evident that bias, discrimination, and prejudice impacts the social, cognitive, and emotional outcomes for individuals with BPD due to the stigma in the healthcare field.

Historically, BPD has been highly stigmatized due to fearfulness surrounding the instability of the sense of self and emotions experienced by those with this disorder. There is also a misconception that those with BPD cannot hold relationships, jobs, or friendships well due to impulsivity and a fear of abandonment that forces them to be distant at times. These misconceptions have unfortunately guided healthcare providers to have prejudice against clients with BPD. In 1899, Emil Kraepelin, a German Psychiatrist introduced personality types into psychiatric classification and placed them under the terms “psychopathic personalities” (Crocq et al., 2013). In the 7th edition of his textbook, Kraepelin assumed that psychopathic personalities

were the consequence of a faulty constitution and that they resulted from psychological inborn "defects". In his 7th edition, he only noted four types of psychopathic personalities: the born criminal*;* the weak-willed; the pathological liars; and the pseudoquerulants (people who insincerely act or pretend to feel obsessively wronged, particularly about minor causes of action). However, in the 8th edition of his textbook, the list was expanded to seven types: the excitable, which is noted as sharing some characteristics with what we now know as Borderline Personality Disorder; the irresolute; persons following their immediate instincts to self gratify; eccentrics*;* pathological liars; enemies of society*;* and the quarrelsome (Crocq et al., 2013). These historical textbooks showcase a lack of empathy and a general lack of knowledge on personality disorders as they are understood today. Through this analysis, it is evident that the misunderstandings of personality disorders, more specifically of BPD, could have extensive impacts on stigmatized individuals.

To make sense of this and to see stigmatization in action, it is important to note that prior research suggests that clinicians report more feelings of anger, frustration, and inadequacy\feelings when working with those who have BPD (Aviram et al., 2006). To add on, when looking at BPD compared to other highly stigmatized disorders such as schizophrenia, attitudes and behaviors towards BPD tended to be more negative. Negative reactions to BPD can lead to issues with treatment, including problems with healthcare providers ending treatment too early, having a lower likelihood of forming an effective treatment alliance with patients, and generally lacking the belief in an individual's recovery (Aviram et al., 2006). The historical context in which BPD was treated and written about has led to the unfortunate stigmas held by people in the healthcare field today. So much so, that healthcare professionals are hesitant to work with those who have BPD (Aviram et al., 2006). Overall, the history of BPD and it's

understanding has been misconstrued and has placed bias, prejudice, stigma and discrimination at the forefront of its treatment in the healthcare field.

From a cognitive standpoint, the prejudice, bias, and stigmas from healthcare workers held against those with BPD have had impacts that correlate with self-stigma, perception, and negativity. Research by Ociskova et al. (2017) suggests that when comparing various groups of health professionals, nurses tend to perceive individuals with BPD in the most judgemental and negative way. In fact, healthcare professionals often use derogatory expressions to describe persons with BPD; these descriptors include: complicated, treatment resistant, demanding, dangerous, manipulative, and attention seeking. Alongside this, a literary analysis done by Ruth el al. (2012) suggests that individuals with BPD endorse a range of BPD-consistent negative beliefs about themselves, the world, and other people, and make negatively biased interpretations and evaluations of both neutral or ambiguous stimuli. They also believe that these tendencies are significantly associated with the severity of their BPD (Ruth et al., 2012). It can be hypothesized that the bias and prejudice those with BPD have faced from healthcare professionals leads them to hold these negative beliefs about themselves and their disorder. Being told about the severity and the various stigmas about a disorder may make one take it on as self-stigma, and further engage assertively, which reflects the self-fulfilling prophecy. The self-fulfilling prophecy begins for those with BPD as a stereotype, and then the stereotype becomes confirmed as the individuals with BPD act accordingly due to their own thoughts and in response to others behaviors towards them.

To further the idea of the self-fulfilling prophecy for those with BPD, it is important to analyze the experiences of significant stigma, particularly at the interface of care delivery that they endure. Past research found that through thirty analyzed studies; 12 on patients perspectives

and 18 on clinicians perspectives, there were six common themes that arose from the synthesis. A few of which included: stigma related to diagnosis and disclosure, perceived un-treatability, stigma as a response to feeling powerless, and stigma due to preconceptions of patients (Ring et al., 2019). Through this analysis used to compare the experiences of stigma towards BPD from the patient and mental health professionals perspectives, there is evidence pointing to the perpetuation of stigma even within the mental health field and general healthcare field, as discussed previously. In turn, the stigma perpetuation cycles into the self-fulfilling prophecy.

Socially, there are clear effects on those with BPD due to stigma and stereotypes as they relate to gender and BPD, and general perception of their disorder. Specifically, Masland and Null (2022) reflected the idea that male individuals with BPD were considered more dangerous and tend to evoke more fear, whereas female individuals were viewed with greater pity and more overall sympathy. This lends itself to the social-roles theory, which states that gender stereotypes reflect people's observations of what women and men do in society. In the case of BPD clients, it is evident that there is a perceived difference between males and females, and this guides stereotypes and stigmas. Due to men being perceived as stronger in society, their mental illness is seen as more intimidating. Society perceives women as weaker and as "damsels in distress" so for this reason, their mental illness is seen as less of a threat, and there is more pity towards them. BPD follows this same idea, and thus showcases social roles theory. In the healthcare field, this can make professionals less likely to want to work with male individuals who have BPD. In this way, they are even more disproportionately impacted.

With all of this being said, there is a great amount of room for improvement to be made by healthcare providers for BPD clients to have better treatment outcomes, less stigmatization from healthcare providers, and less self-stigma. Those who work in the healthcare and mental

health fields must have more extensive education and continuous supervision to manage the negative counter-transference, stigmatizing beliefs and overall behavior towards those with BPD. Research done by Knaak et al. (2015) suggests that an intervention specifically on BPD for healthcare providers can be beneficial to reducing bias and prejudice. In a study done on stigmatization towards persons with BPD, stigmatization towards persons with a mental illness were measured with the Opening Minds Scale for Healthcare Providers scale. They were asked to what extent they agree or disagree with a series of items on a 5-point scale, and it compared answers to being told a coworker reported to them that they had BPD vs. if a coworker reported to them that they had a different mental illness. Results showed that intervention was successful at improving healthcare provider attitudes and behavioral intentions towards persons with BPD. This suggests that anti-stigma interventions can be effective at combating stigma against specific disorders, including BPD (Knaak et al., 2015).

Without understanding stigma, biases, and prejudice held against individuals with BPD, there will continue to be a lack of proper care for these clients. In conclusion, bias, discrimination, and prejudice impacts the social, cognitive, and emotional outcomes for individuals with Borderline Personality Disorder due to the stigma in the healthcare field, but there are ways to begin reducing that stigma in hopes of lessening healthcare outcomes for these people.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi-org.ezproxy.frederick.edu/10.1176/appi.books.9780890425596

Aviram, R. B., Brodsky, B. S., & Stanley, B. (2006). Borderline Personality Disorder, stigma, and treatment implications. *Harvard Review of Psychiatry, 14*(5), 249–256. https://doi.org/10.1080/10673220600975121

Crocq M. A. (2013). Milestones in the history of personality disorders. *Dialogues in clinical neuroscience*, *15*(2), 147–153. https://doi.org/10.31887/DCNS.2013.15.2/macrocq

Knaak, S., Szeto, A. C. H., Fitch, K., Modgill, G., & Patten, S. (2015). Stigma towards borderline personality disorder: Effectiveness and generalizability of an anti-stigma program for healthcare providers using a pre-post randomized design. *Borderline Personality Disorder and Emotion Dysregulation*, *2*(1).

Masland, S. R., & Null, K. E. (2022). Effects of diagnostic label construction and gender on stigma about borderline personality disorder. *Stigma and Health, 7*(1), 89–99. https://doi.org/10.1037/sah0000320

Ociskova, M., Prasko, J., Latalova, K., Sedlackova, Z., Kamaradova, D., Sandoval, A., & Grambal, A.. (2017). F*ck your care if you label me! Borderline personality disorder, stigma, and self-stigma. *Activitas Nervosa Superior Rediviva. 59.* 16-22.

Ring, D., & Lawn, S. (2019). Stigma perpetuation at the interface of mental health care: a review to compare patient and clinician perspectives of stigma and borderline personality

disorder. *Journal of mental health (Abingdon, England)*, 1–21. Advance online publication. https://doi.org/10.1080/09638237.2019.1581337

Baer, R. A., Peters, J. R., Eisenlohr-Moul, T. A., Geiger, P. J., & Sauer, S. E. (2012). Emotion-related cognitive processes in borderline personality disorder: a review of the empirical literature. *Clinical psychology review*, *32*(5), 359–369. https://doi.org/10.1016/j.cpr.2012.03.002